		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010660

Facility Name: CARLYLE HEALTHCARE CENTER

Address: 501 CLINTON STREET (Number) CARLYLE (City) 62231 (Zip Code)

County: CLINTON

Telephone Number: 618-594-3112 **Fax #** 618-594-2393

IDPA ID Number: 37-0997048001

Date of Initial License for Current Owners: 04/01/69

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DAVE REIS **Telephone Number:** 217-228-1950

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) DAVID L. REIS PRESIDENT
(Firm Name & Address) WDM COMPUTER SERVICES 1900 HARRISON QUINCY
(Telephone) 217-228-1950 Fax # 217-222-6053

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	54	Skilled (SNF)	54	19,764	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,620	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	124	TOTALS	124	45,384	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,087		1,024	25,111	8
9	SNF/PED					9
10	ICF		16,795		16,795	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,087	16,795	1,024	41,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

D. How many bed-hold days during this year were paid by Public Aid?
127 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/01/69

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 6 and days of care provided _____

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2000 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	230,184	10,613	5,637	246,434		246,434		246,434			1
2	Food Purchase		155,853		155,853		155,853	(4,149)	151,704			2
3	Housekeeping	89,170	16,278		105,448		105,448		105,448			3
4	Laundry	63,949	23,682	417	88,048		88,048		88,048			4
5	Heat and Other Utilities			98,272	98,272		98,272		98,272			5
6	Maintenance	81,943	32,834	41,054	155,831		155,831		155,831			6
7	Other (specify):*											7
8	**TOTAL General Services**	465,246	239,260	145,380	849,886		849,886	(4,149)	845,737			8
	B. Health Care and Programs											
9	Medical Director			3,836	3,836		3,836		3,836			9
10	Nursing and Medical Records	1,197,630	137,969	840	1,336,439		1,336,439	(2,460)	1,333,979			10
10a	Therapy	85,731	1,778	18,501	106,010		106,010		106,010			10a
11	Activities	65,085	7,855	13,914	86,854		86,854	(1,208)	85,646			11
12	Social Services	19,777		2,339	22,116		22,116		22,116			12
13	Nurse Aide Training											13
14	Program Transportation	1,877	2,779		4,656		4,656	(2,048)	2,608			14
15	Other (specify):* SALES TAXES			5,898	5,898		5,898	(5,898)				15
16	**TOTAL Health Care and Programs**	1,370,100	150,381	45,328	1,565,809		1,565,809	(11,614)	1,554,195			16
	C. General Administration											
17	Administrative	219,349			219,349		219,349		219,349			17
18	Directors Fees											18
19	Professional Services			396,836	396,836		396,836	(395,140)	1,696			19
20	Dues, Fees, Subscriptions & Promotions			28,720	28,720		28,720	(23,042)	5,678			20
21	Clerical & General Office Expenses	83,951	15,837	18,372	118,160		118,160		118,160			21
22	Employee Benefits & Payroll Taxes			266,136	266,136		266,136	(5,791)	260,345			22
23	Inservice Training & Education			4,114	4,114		4,114		4,114			23
24	Travel and Seminar			3,182	3,182		3,182		3,182			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			24,134	24,134		24,134		24,134			26
27	Other (specify):* NON HEALTHCARE			3,043	3,043		3,043	(3,043)				27
28	**TOTAL General Administration**	303,300	15,837	744,537	1,063,674		1,063,674	(427,016)	636,658			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,138,646	405,478	935,245	3,479,369		3,479,369	(442,779)	3,036,590			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER #0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			96,050	96,050		96,050	166	96,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,850	44,850		44,850	(14,580)	30,270			32
33	Real Estate Taxes			29,763	29,763		29,763		29,763			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* BAD DEBTS			5,218	5,218		5,218	(5,218)				36
37	**TOTAL Ownership**			175,881	175,881		175,881	(19,632)	156,249			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation		2,779		2,779		2,779	(2,047)	732			38
39	Ancillary Service Centers		158,806		158,806		158,806	(12,350)	146,456			39
40	Barber and Beauty Shops		2,878	13,169	16,047		16,047		16,047			40
41	Coffee and Gift Shops		9,610		9,610		9,610		9,610			41
42	Provider Participation Fee			68,135	68,135		68,135		68,135			42
43	Other (specify):* PENALTY			6,487	6,487		6,487	(6,487)				43
44	**TOTAL Special Cost Centers**		174,073	87,791	261,864		261,864	(20,884)	240,980			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,138,646	579,551	1,198,917	3,917,114		3,917,114	(483,295)	3,433,819			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,805)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(2,460)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(14,603)	32		10
11	Discounts, Allowances, Rebates & Refunds	(344)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,898)	15		13
14	Non-Care Related Interest	(1,208)	11		14
15	Non-Care Related Owner's Transactions	(395,140)	19		15
16	Personal Expenses (Including Transportation)	(4,095)	14,38		16
17	Non-Care Related Fees	(3,043)	27		17
18	Fines and Penalties	(6,487)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(5,791)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,218)	36		24
25	Fund Raising, Advertising and Promotional	(23,042)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule PHARMACY BILLING	(12,350)	39		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (483,484)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,410	30,32	34
35	Other- Attach Schedule SCHEDULE X1	(1,221)	30	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 189		36
37	**TOTAL ADJUSTMENTS (A) and (B) (sum of SUBTOTALS)**	$ (483,295)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CARLYLE HEALTHCARE CENTER

ID# 0011066O

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
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51				51
52				52
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56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,149)	0	0	0	0	0	0	0	0	0	0	(4,149)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,149)	0	0	0	0	0	0	0	0	0	0	(4,149)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,460)	0	0	0	0	0	0	0	0	0	0	(2,460)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,208)	0	0	0	0	0	0	0	0	0	0	(1,208)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(5,898)	0	0	0	0	0	0	0	0	0	0	(5,898)	15
16	**TOTAL Health Care and Programs**	(9,566)	0	0	0	0	0	0	0	0	0	0	(9,566)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(395,140)	0	0	0	0	0	0	0	0	0	0	(395,140)	19
20	Fees, Subscriptions & Promotions	(23,042)	0	0	0	0	0	0	0	0	0	0	(23,042)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(5,791)	0	0	0	0	0	0	0	0	0	0	(5,791)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,043)	0	0	0	0	0	0	0	0	0	0	(3,043)	27
28	**TOTAL General Administration**	(427,016)	0	0	0	0	0	0	0	0	0	0	(427,016)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(440,731)	0	0	0	0	0	0	0	0	0	0	(440,731)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,221)	1,387	0	0	0	0	0	0	0	0	0	166	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,603)	23	0	0	0	0	0	0	0	0	0	(14,580)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(5,218)	0	0	0	0	0	0	0	0	0	0	(5,218)	36
37	**TOTAL Ownership**	(21,042)	1,410	0	0	0	0	0	0	0	0	0	(19,632)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,487)	0	0	0	0	0	0	0	0	0	0	(6,487)	43
44	**TOTAL Special Cost Centers**	(6,487)	0	0	0	0	0	0	0	0	0	0	(6,487)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(468,260)	1,410	0	0	0	0	0	0	0	0	0	(466,850)	45

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DOROTHY MESSICK	51	ST. VINCENTS HOME INC.	QUINCY	WDM HEALTH SVCS	QUINCY	LEASING
ANN REIS	24	CLINTON MANOR	NEW BADEN			
SUE GRAY	24					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	DEPRECIATION	$	WDM HEALTH SVCS /LEASING		$ 1,387	$ 1,387	1
2	V	32	INTEREST		CAPITALIZED LEASE		23	23	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 1,410	$ * 1,410	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DOROTHY MESSICK	PRESIDENT	CARLYLE	51.00		20	50.00	WAGES	$ 100,000	17-1	1
2	ANN REIS	SECRETARY	CARLYLE	24.00		19	48.00	WAGES	28,000	17-1	2
3	SUE GRAY	TREAS	CARLYLE	24.00		20	50.00	WAGES	28,000	17-1	3
4											4
5	DOROTHY MESSICK	PRESIDENT	ST.VINCENTS		0	20	50.00				5
6	ANN REIS	SECRETARY	ST.VINCENTS		0	19	48.00				6
7	SUE GRAY	TREAS	ST.VINCENTS		0	20	50.00				7
8											8
9	CARLYLE HEALTHCARE OWNES ST VINCENTS			100.00							9
10											10
11	ANN REIS		CLINTON MANO	25.00		2	4.00				11
12											12
13								TOTAL	$ 156,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST NATIONAL BANK		X	MORTGAGE	$11,500.00	10/19/99	$ 1,052,473	$ 994,741	10/19/02	7.7500	$ 44,850	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CAPITALIZED LEASE	X		INTEREST							23	6
7												7
8												8
9	TOTAL Facility Related				$11,500.00		$ 1,052,473	$ 994,741			$ 44,873	9
	B. Non-Facility Related*											
10	INVESTMENT INTEREST										(14,603)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,603)	14
15	TOTALS (line 9+line14)						$ 1,052,473	$ 994,741			$ 30,270	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	39,341	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	41,760	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,419	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	27,344	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	29,763	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	30,782	8
	1996	30,203	9
	1997	31,484	10
	1998	43,006	11
	1999	41,760	12

*REDUCED BY 12000 ALLOCATED FOR ASSISTED LIVING

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 69,374 B. General Construction Type: Exterior BRICK Frame WOOD,STEEL Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

MEDCIAL CLINIC 2205 SQ FT 1 BUILDING DIVISION 2
KREBS VILLAGE 11112 SQ FT 6 BUILDINGS DIVISION 1
ASSISTED LIVING 8334 SQ FT 1 BUILDING DIVISION 5

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	48,438,720	1969	$ 103,500	1
2					2
3	TOTALS	48,438,720		$ 103,500	3

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		1969	1969	$ 30,426	$	30	$	$	$ 30,426	4
5	4		1988	1988	99,400	3,313	30	3,313		40,036	5
6	1		1977	1977	21,293	716	30	716		16,877	6
7	25		1973	1973	138,148	4,679	30	4,679		128,400	7
8	3		1993	1993	399,471	13,360	30	13,360		106,662	8
	Improvement Type**										
9	42 BUILDING ADDTN			1974	183,451	6,193	30	6,193		162,291	9
10	GERIATIC CENTER			1975	15,496	522	30	522		13,405	10
11	REHAB CENTER			1978	10,750	358	30	358		8,240	11
12	SPRINKLER			1974	32,694		25			32,694	12
13	BUILDING IMPROVMT			1975	14,572		20			14,572	13
14	BUILDING IMPROVMT			1970	1,588		20			1,588	14
15	BUILDING IMPROVMT			1973	3,328		20			3,328	15
16	BUILDING IMPROVMT			1974	825		20			825	16
17	PLAN OF CORRECTN			1975	21,969		20			20,969	17
18	GUARDS			1980	1,379		8			1,379	18
19	ALARM SYSTEM			1980	1,200		8			1,200	19
20	BUILDING IMPVMT GARAGE			1984	12,050		15			12,050	20
21	LAND IMPROVMTS			1987	37,715	1,919	20	1,919		25,698	21
22	BUILDING IMPVMT			1988	30,824		20	1,541	1,541	19,005	22
23	BUILDING ADTN GLASS ENCLOSER			1986	319,491	10,650	30	10,650		150,871	23
24	ROOM REMODELING			1988	16,596	553	30	553		6,684	24
25	ROOM REMODELING			1989	1,948	65	30	65		776	25
26	WINDOWS			1989	3,230	108	30	108		1,257	26
27	ROOF			1989	11,294	384	30	384		4,383	27
28	SMOKE DET			1980	2,204		8			2,204	28
29	BUILDING IMPVMT			1993	4,932	501	10	501		3,888	29
30	HANDRAILS			1991	6,574		8			6,574	30
31	CUBICLE CURTAINS			1992	8,415		10	842	842	7,578	31
32	FRONT PORCH ADTN			1997	85,961	2,587	33	2,587		8,569	32
33	ELEVATOR			1997	83,288	4,164	20	4,164		12,840	33
34	LANDSCAPING/RAILING			1997	8,550	570	15	570		1,757	34
35	LAND IMPROVMTS			1993	51,227	3,441	15	3,441		24,904	35
36	TOTAL (lines 4 thru 35)				$ 1,660,289	$ 54,083		$ 56,466	$ 2,383	$ 871,930	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF REPAIR			1995	8,974	907	10	907		4,891	9
10	FLOOR TILE			1995	7,178	482	15	482		2,402	10
11	FLOOR CORRECTION			1999	28,360	1,417	20	1,417		2,490	11
12	HALLWAY REMODELING			1999	10,315	1,032	15	1,032		1,633	12
13	NEW ROOF CTR/BOILER			2000	19,203	1,091	15	1,091		1,091	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 74,030	$ 4,929		$ 4,929	$	$ 12,507	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 244,844	$ 26,341	$ 27,728	$ 1,387		$ 124,086	37
38	Current Year Purchases	42,097	3,587	3,587		8	3,587	38
39	Fully Depreciated Assets	93,820				8	93,820	39
40								40
41	TOTALS	$ 380,761	$ 29,928	$ 31,315	$ 1,387		$ 221,493	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	FACILITY	BUS	1998	$ 17,531	$ 3,506	$ 3,506	$	5	$ 9,642	42
43	FACILITY	90 CHEV WAGON	1990	8,612				5	8,612	43
44	FACILITY	1988 CHEV VAN	1993	12,623				3	12,623	44
45		ADM AUTO	1995		3,604		(3,604)			45
46	TOTALS			$ 38,766	$ 7,110	$ 3,506	$ (3,604)		$ 30,877	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	2,257,346	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	96,050	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	96,216	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	166	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,136,807	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	ADM AUTO	$ 14,005	$ 3,604	$ 14,005	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 14,005	$ 3,604	$ 14,005	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				158,806		158,806	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): PHARMACY BILLING								(12,350)	13
14	TOTAL			$		$	$ 158,806		$ 146,456	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 385,776	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	568,811		3
4	Supply Inventory (priced at)	10,702		4
5	Short-Term Investments	722,582		5
6	Prepaid Insurance	13,957		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	155,466		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,857,294	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(42,555)		12
13	Land	128,950		13
14	Buildings, at Historical Cost	2,690,074		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	677,980		16
17	Accumulated Depreciation (book methods)	(1,571,025)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,883,424	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,740,718	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 67,205	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	139,954		30
31	Accrued Taxes Payable (excluding real estate taxes)	(1,529)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,667		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(83,107)		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 170,190	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	994,741		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	DEFERRED INCOME TRUSTS	95,182		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,089,923	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,260,113	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,480,605	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,740,718	$	48

***(See instructions.)**

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,220,133	1
2	Restatements (describe):		2
3	1999 TAX ADJUSTMENTS	(71,480)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,148,653	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	245,522	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) OTHER DIVISIONS	86,430	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 331,952	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,480,605	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,874,631	1
2	Discounts and Allowances for all Levels	(37,605)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,837,026	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	56,814	6
7	Oxygen	5,635	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 62,449	8
	C. Other Operating Revenue		
9	Payments for Education	3,612	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	10,088	12
13	Barber and Beauty Care	15,197	13
14	Non-Patient Meals	3,805	14
15	Telephone, Television and Radio	4,095	15
16	Rental of Facility Space		16
17	Sale of Drugs	206,789	17
18	Sale of Supplies to Non-Patients	2,460	18
19	Laboratory	25,990	19
20	Radiology and X-Ray	3,820	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 275,856	23
	D. Non-Operating Revenue		
24	Contributions	7,802	24
25	Interest and Other Investment Income***	14,603	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,405	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	REBATES	344	28
28a	ACTIVITIES	1,208	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,552	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,199,288	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	849,886	31
32	Health Care	1,565,786	32
33	General Administration	1,063,674	33
	B. Capital Expense		
34	Ownership	175,904	34
	C. Ancillary Expense		
35	Special Cost Centers	193,729	35
36	Provider Participation Fee	68,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,917,114	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,174	41
42	**Income Taxes**	(36,652)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 245,522	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,088	$ 44,958	$ 21.53	1
2	Assistant Director of Nursing	1,926	2,088	33,618	16.10	2
3	Registered Nurses	16,444	17,512	265,801	15.18	3
4	Licensed Practical Nurses	17,026	18,144	233,430	12.87	4
5	Nurse Aides & Orderlies	66,797	70,170	619,823	8.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,852	7,124	85,731	12.03	8
9	Activity Director	5,875	6,075	51,891	8.54	9
10	Activity Assistants	1,649	1,793	13,194	7.36	10
11	Social Service Workers	1,946	2,186	19,777	9.05	11
12	Dietician					12
13	Food Service Supervisor	2,189	2,397	29,526	12.32	13
14	Head Cook	2,074	2,184	23,884	10.94	14
15	Cook Helpers/Assistants	9,167	9,959	83,655	8.40	15
16	Dishwashers	14,769	15,457	93,119	6.02	16
17	Maintenance Workers	6,608	7,085	81,943	11.57	17
18	Housekeepers	12,882	13,620	89,170	6.55	18
19	Laundry	8,623	9,223	63,949	6.93	19
20	Administrator	2,048	2,088	63,349	30.34	20
21	Assistant Administrator					21
22	Other Administrative	4,524	4,524	156,000	34.48	22
23	Office Manager					23
24	Clerical	7,066	7,773	83,951	10.80	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) TRANSPORTAN	256	256	1,877	7.33	33
34	TOTAL (lines 1 - 33)	190,649	201,746	$ 2,138,646 *	$ 10.60	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	129	$ 5,637	1-3	35
36	Medical Director	60	3,836	9-3	36
37	Medical Records Consultant	24	840	10-2	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	207	14,240	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	95	4,261	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant	37	2,339	12-3	45
46	Other(specify) RELIGIOUS		13,914	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	552	$ 45,067		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOANN BRAVE	ADM		$ 63,349
DOROTHY MESSICK	WK OFCR	51.0	100,000
ANN REIS	WK OFCR	25.0	28,000
SUE GRAY	WK OFCR	25.0	28,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 219,349

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
WDM HEALTH SERVICES INC	MANAGEMENT	350,067
HERMAN BODEWES	LEGAL	1,696
WDM COMPUTER SERV INC.	ACT/DATA PROCESS	45,073
NON ALLOW		(395,140)
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,696

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,960
Unemployment Compensation Insurance	16,196
FICA Taxes	158,288
Employee Health Insurance	34,901
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OFFICER INSURANCE	5,791
NON ALLOW	(5,791)
TOTAL (agree to Schedule V, line 22, col.8)	$ 260,345

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 260
Advertising: Employee Recruitment	3,282
Health Care Worker Background Check	
(Indicate # of checks performed 31)	372
ILL SEC IF STATE	638
MAG SUBSCRIPTIONS	871
CORP FEES	255
ADVERTISING	23,042
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	(23,042)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,678

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHED LIST	2,251
MEALS	931
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,182

**See instructions.

Facility Name & ID Number CARLYLE HEALTHCARE CENTER # 0010660 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARLYLE HEALTHCARE CENTER **#** 0010660 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **8YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **30,506** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **68,135**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,805**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **50**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **N**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.